



DEPARTMENT OF STATE HEALTH SERVICES VITAL STATISTICS

TEXAS DEPARTMENT OF STATE HEALTH SERVICES - VITAL STATISTICS
Dec 07 2020

STATE OF TEXAS CERTIFICATE OF DEATH			STATE FILE NUMBER		
			(Before Marriage) 142-20-221010		
1. LEGAL NAME OF DECEASED (Include AKA's, if any) (First, Middle, Last) KEVIN WAYNE CLARK			2. DATE OF DEATH - ACTUAL OR PRESUMED (mm-dd-yyyy) FOUND NOVEMBER 24, 2020		
3. SEX	4. DATE OF BIRTH (mm-dd-yyyy)	5. AGE-Last Birthday (Years)	IF UNDER 1 YR Mo	IF UNDER 1 DAY Days	Hours Min
MALE	SEPTEMBER 27, 1954	66			
7. SOCIAL SECURITY NUMBER	8. MARITAL STATUS AT TIME OF DEATH		9. SURVIVING SPOUSE'S NAME (If spouse, give name prior to first marriage)		
468-70-2168	<input type="checkbox"/> Married	<input type="checkbox"/> Widowed (but not remarried)	<input type="checkbox"/> Divorced (but not remarried)	<input checked="" type="checkbox"/> Never Married	<input type="checkbox"/> Unknown
10a. RESIDENCE STREET ADDRESS 550 VZCR 4707			10b. APT. NO.	10c. CITY OR TOWN BEN WHEELER	
10d. COUNTY	10e. STATE	10f. ZIP CODE	10g. INSIDE CITY LIMITS? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
VAN ZANDT	TEXAS	75754			
11. FATHER/PARENT 2 NAME PRIOR TO FIRST MARRIAGE DONALD WESLEY CLARK			12. MOTHER/PARENT 1 NAME PRIOR TO FIRST MARRIAGE HAZEL LOUISE ROONEY		
13. PLACE OF DEATH (CHECK ONLY ONE)					
<input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		<input type="checkbox"/> Hospice Facility <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Decedent's Home <input type="checkbox"/> Other (Specify)			
14. COUNTY OF DEATH	15. CITY/TOWN, ZIP (IF OUTSIDE CITY LIMITS, GIVE PRECINCT NO.)		16. FACILITY NAME (If not institution, give street address)		
VAN ZANDT	BEN WHEELER, 75754		550 VZCR 4707		
17. INFORMANT'S NAME & RELATIONSHIP TO DECEASED KAYE DOOLEY - SISTER			18. MAILING ADDRESS OF INFORMANT (Street and Number,City,State,Zip Code) 357 LAKE AVENUE SOUTH, SPICER, MN 56288		
19. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Entombment <input type="checkbox"/> Removal from state <input type="checkbox"/> Mausoleum <input type="checkbox"/> Other (Specify)		20. SIGNATURE AND LICENSE NUMBER OF FUNERAL DIRECTOR OR PERSON ACTING AS SUCH BRIAN A. BASS, BY ELECTRONIC SIGNATURE - 10921		21. <input checked="" type="checkbox"/> Unknown Section _____ Block _____ Lot _____ Space _____	
22. PLACE OF DISPOSITION (Name of cemetery, crematory, other place) EUBANK CEDAR CREEK CREMATION			23. LOCATION (City,Town, and State) MABANK, TX		
24. NAME OF FUNERAL FACILITY EUBANK FUNERAL HOME, INC.			25. COMPLETE ADDRESS OF FUNERAL FACILITY (Street and Number, City, State, Zip Code) 27532 STATE HWY. 64, CANTON, TX 75103		
26. CERTIFIER (Check only one) <input type="checkbox"/> Certifying physician-To the best of my knowledge, death occurred due to the cause(s) and manner stated. <input checked="" type="checkbox"/> Medical Examiner/Judge of the Peace - On the basis of examination, and/or investigation, in my opinion, death occurred at the time,date and place, and due to the cause(s) and manner stated.					
27. SIGNATURE OF CERTIFIER SCOTT SHINN , BY ELECTRONIC SIGNATURE			28. DATE CERTIFIED (mm-dd-yyyy)	29. LICENSE NUMBER	30. TIME OF DEATH(Actual or presumed)
			DECEMBER 4, 2020		02:15 PM
31. PRINTED NAME, ADDRESS OF CERTIFIER (Street and Number, City, State, Zip Code) SCOTT SHINN 1540 FM 279, BEN WHEELER, TX 75754					
32. TITLE OF CERTIFIER JP					
33. PART 1. ENTER THE CHAIN OF EVENTS - DISEASES, INJURIES, OR COMPLICATIONS - THAT DIRECTLY CAUSED THE DEATH. DO NOT ENTER TERMINAL EVENTS SUCH AS CARDIAC ARREST, RESPIRATORY ARREST, OR VENTRICULAR FIBRILLATION WITHOUT SHOWING THE ETIOLOGY. DO NOT ABBREVIATE. ENTER ONLY ONE CAUSE ON EACH.					
IMMEDIATE CAUSE (Final disease or condition → resulting in death)					
a. COVID-19 Due to (or as a consequence of): _____ b. _____ Due to (or as a consequence of): _____ c. _____ Due to (or as a consequence of): _____ d. _____					
Approximate interval Onset to death WEEKS					
34. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
35. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> No					
36. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined					
37. DID TOBACCO USE CONTRIBUTE TO DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Previously <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		38. IF FEMALE: <input type="checkbox"/> Not pregnant within past year <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Not pregnant, but pregnant within 42 days of death <input type="checkbox"/> Not pregnant, but pregnant 43 days to one year before death <input type="checkbox"/> Unknown if pregnant within the past year		39. IF TRANSPORTATION INJURY, SPECIFY: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (Specify)	
40a. DATE OF INJURY(mm-dd-yyyy)	40b. TIME OF INJURY	40c. INJURY AT WORK?	40d. PLACE OF INJURY (e.g. Decedent's home, construction site, restaurant, wooded area) <input type="checkbox"/> Yes <input type="checkbox"/> No		
40e. LOCATION (Street and Number, City,State,Zip Code)				40f. COUNTY OF INJURY	
41. DESCRIBE HOW INJURY OCCURRED					
42a. REGISTRAR FILE NO.	42b. DATE RECEIVED BY LOCAL REGISTRAR	42c. REGISTRAR			

EDR NUMBER 00004444884647

This is a true and correct copy of the record as registered in the State of Texas. Issued under the authority of Section 191.051, Health and Safety Code.

ISSUED Dec 11 2020

TARA DAS
STATE REGISTRAR

WARNING: THIS DOCUMENT HAS A DARK BLUE BORDER AND A COLORED BACKGROUND



VS-112 REV 1/2006

WARNING
The penalty for knowingly making a false statement in this form can be 2-10 years in prison and
a fine up to \$10,000. (Health and Safety Code, Sec. 195, 1989)

Q A 1 7 9 2 5 0 7 8